Deficiency Citation - Case Study of Mr. George Cain
(Unintended Weight Loss)

TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 325 S/S=J	42 CFR 483.25(i)(1) Nutrition Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This requirement is not met as evidenced by: Based on medical record review, interviews and observations, the facility failed to prevent the unintentional weight loss of one resident (R1) in the sample of 15. Findings include: A review of R1's current care plan, which was dated January XXXX, revealed that R1, needed some ADL assistance. During observation of breakfast on June 10, XXXX between 8:30 a.m. and 9:00 a.m., the Certified Nursing Assistant 1(CNA1), who was in and out of R1's room, did not provide cueing or encouragement to eat and did not open containers or provide food preparation assistance to R1. R1 was served orange juice, toast, cereal, a hardboiled egg, 4 ounces of milk, a cup of coffee and a container of a protein supplement. R1 ate 75% of the hot cereal and milk, but did not eat the toast, or hard-boiled egg, which was in the shell. The resident drank the coffee but did not drink the supplement or juice. The supplement was in a sealed cardboard carton and the orange juice was in a plastic cup with an aluminum foil top and neither had been opened. The toast had not been buttered nor had the jam been opened. The hard-boiled egg had not been shelled. CNA1 came into the room at 9:00 a.m. and asked R1 if R1 had finished eating. R1, "Yes." CNA1, who did not encourage R1 to eat any of the uneaten food items on the tray, removed the tray, placing the unopened supplement and orange juice on the windowsill. There were 3 unopened containers of supplement on the windowsill. R1 asked the surveyor if R1 could have another cup of coffee. CNA1 answered R1, saying CNA 1would get R1 a cup and left the room. During observation of the supper meal from 5:00 p.m. to 5:45 p.m. on June 11, XXXX an unopened container of supplement was placed on R1's tray table. There were four unopened containers of supplement on R1's windowsill. Of the six food items provided at the supper meal, R1 did not eat any of the chopped roast beef, which was covered with gravy. R1 ate 50% of the mashed potatoes, 75% of the green beans, and 100% of the ice cream. R1 did not consume the bread or the supplement. CNA 6 was in and out of R1's room twice during this observation, and CNA 6 provided no assistance to open containers, no encouragement or cueing to eat, and no offer of a substitute for the meat with gravy. According to record review, R1 has a diagnosis of congestive heart failure and arthritis. The resident's admission records of January XXXX, revealed that the resident was 5 feet and 10 inches tall and weighed 180 pounds, and according to staff, that was the resident's usual body

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	weight. The medical record revealed that in December XXXX, the resident weighed 150 pounds. A significant change comprehensive assessment was conducted at that time. The dates of the last lab tests conducted were December XXXX, and the lab test values recorded indicated unacceptable nutritional status: albumen-2.8 (normal 3.4-4.8 g/dl); potassium-2.9 (normal 3.5-5.0 mEq/L); hemoglobin-10 (normal 14-17 g/dl). Notations in the resident's record since December XXXX included: 5/7/XXXX - more dependence with Activities of Daily Living (ADLs) due to limitations in functional range of motion in neck, hips, and ankles; 5/07/00-protein supplement ordered two times per day and resident refuses to be fed. During the tour on June 9, XXXX at 8:45 a.m., R1 was observed with dry and cracked lips and mouth. R1 stated that R1 was finished with breakfast, however, R1 had only consumed 25% of the breakfast served. There was an unopened container of supplement out of the R1's reach on the bedside table.